Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

USMD HOSPITAL AT FORT WORTH
5700 DIRKS ROAD
FORT WORTH TX 76132

Respondent Name
NEW HAMPSHIRE INSURANCE COMPANY

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-09-A022-01

MFDR Date Received
June 26, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "According to Cambridge we are billing with the incorrect Medicare number . . . However, the Medicare number became effective as of 6/6/08 per CMS . . ."

Amount in Dispute: $25,026.40

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier asserts that it has paid according to applicable fee guidelines and/or reduced to fair and reasonable."

Response Submitted by: Flahive, Ogden & Latson, 504 Lavaca, Suite 1000, Austin, Texas 78701

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
September 10, 2008 to September 11, 2008	Inpatient Hospital Services	$25,026.40	$6,698.31

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.404 sets out the fee guidelines for inpatient hospital services
3. 28 Texas Administrative Code §133.2 defines words and terms related to medical billing and processing.
4. 28 Texas Administrative Code §133.10 sets out the requirements for billing forms and formats.
5. 28 Texas Administrative Code §133.200 sets out procedures for insurance carriers upon receipt of medical bills.
6. *Texas Clean Claim and Electronic Medical Billing and Payment Companion Guides* (Version 2.0) sets out the Division instructions related to submission of required billing forms.
7. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.

8. No explanations of benefits or documentation of provider payment were submitted for review. The requestor submitted two letters from the insurance carrier documenting that the medical bills were returned with the notation "PLEASE RESUBMIT WITH A VALID MEDICARE #. . . ."

Issues

1. Did the insurance carrier properly return an incomplete bill submitted by the health care provider?
2. Are the disputed services subject to a contractual agreement between the parties to this dispute?
3. What is the applicable rule for determining reimbursement for the disputed services?
4. What is the recommended payment amount for the services in dispute?
5. Is the requestor entitled to reimbursement?

Findings

1. Documentation supports that the insurance carrier returned the health care provider's bills as incomplete, with the notation "PLEASE RESUBMIT WITH A VALID MEDICARE # PER TEXAS GUIDELINES," and "PLEASE RESUBMIT WITH A VALID MEDICARE # . . . THE MEDICARE # SUBMITTED WAS NOT VALID UNTIL 10/1/08." Division rule at 28 Texas Administrative Code §133.200(c) provides that "The proper return of an incomplete medical bill in accordance with this section fulfills the insurance carrier's obligations with regard to the incomplete bill." However, §133.200(a)(1) requires that "Insurance carriers shall not return medical bills that are complete, unless the bill is a duplicate bill." 28 Texas Administrative Code §133.2 defines a complete medical bill as "A medical bill that contains all required fields as set forth in the billing instructions for the appropriate form specified in §133.10 of this chapter (relating to Required Billing Forms/Formats)." 28 Texas Administrative Code §133.10(d) specifies that "All information submitted on required billing forms must be legible and completed in accordance with Division instructions." The applicable Division instructions are found in the *Texas Clean Claim and Electronic Medical Billing and Payment Companion Guides* (version 2.0). Review of Division instructions finds no requirement that the health care provider submit a Medicare number. The Division notes that the requestor provided documentation to support that its Medicare provider identification number was effective June 6, 2008; however, this is unnecessary, as no requirement is found within Division rules that the health care provider submit, or even possess, a Medicare provider identification number to be eligible for reimbursement. The respondent's position statement asserts that "The carrier asserts that it has paid according to applicable fee guidelines and/or reduced to fair and reasonable." No explanation of benefits or documentation of payment were found to support that the insurance carrier made any payment according to applicable fee guidelines and/or reduced payment to a fair and reasonable reimbursement. The insurance carrier's rationale for returning the medical bill to the health care provider is not supported. The Division concludes that the return of the medical bill was not proper; the insurance carrier did not meet the requirements of §133.200(a)(1).
2. Review of the submitted information finds no documentation to support that the disputed services are subject to a contractual fee agreement between the parties to this dispute.
3. This dispute relates to facility services performed in an inpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.404, the *Hospital Facility Fee Guideline – Inpatient*. Per §134.404(f), the reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.404(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 143 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables in accordance with subsection (g). Review of the submitted documentation finds that separate reimbursement for implantables was not requested.
4. Per §134.404(f)(1)(A), the maximum allowable reimbursement (MAR) is calculated by multiplying the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount, determined in accordance with the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors, by 143%. Information regarding the calculation of Medicare IPPS payment rates may be found at http://www.cms.gov. The DRG code assigned to the disputed services is 512. The services were provided at USMD Hospital at Fort Worth. Consideration of the assigned DRG, location of the services, and bill-specific information results in a total Medicare facility specific reimbursement amount of $4,684.13. This amount multiplied by 143% results in a MAR of $6,698.31.
5. The maximum allowable reimbursement for the disputed services is $6,698.31. This amount less the amount previously paid by the insurance carrier of $0.00 leaves an amount due to the requestor of $6,698.31. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $6,698.31.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $6,698.31, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	March 21, 2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.